

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL OF ANDERSON AND MADISC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1515 N MADISON AVE ANDERSON, IN 46011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The survey was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00162023 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Date: 3-04-15</p> <p>Facility Number: 005100</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>Community Hospital of Anderson and Madison County is in compliance with 410 IAC 15-1.6-4, Outpatient services, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/25/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE